Testimony Submitted by:
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Good morning and thank you for giving me the opportunity to speak with you today. My name is Mary Mayhew. I am a senior fellow with the Opportunity Solutions Project. We are a non-partisan organization dedicated to sharing proven state-level best practices in welfare reform-nationwide to help expand opportunity for all. I am also here as a former Commissioner of the Maine Department of Health & Human Services.

The Opportunity Solutions Project and its sister organization, the Foundation for Government Accountability, have been conducting research, publishing analysis, and sharing data regarding the impact of Medicaid expansion across the country over the last several years. We are opposed to Medicaid expansion.

This morning, I want to share with you some data from the various states which have expanded, the impact on state priorities, and my experience with Maine's previous Medicaid expansion.

When Medicaid was first established in the 1960s, the focus was to provide healthcare and critical services to the elderly, the disabled, and extremely low-income families. Traditional Medicaid also covers pregnant women and children at substantially higher income levels. The Medicaid expansion included within the Affordable Care Act which is now optional to states based on the Supreme Court striking down the Congressional mandate to expand Medicaid, is focused solely on non-elderly, non-disabled adults between the age of 19 and 64.

Most state Medicaid programs spend 80% of their funding on 20% of their population and 50% on 5%. The top 20% of your Medicaid program is primarily comprised of the elderly, the disabled, and individuals with severe and persistent mental illness. Imagine the 80 year old couple with a 40 year old adult son with Down Syndrome or the 78 year old with dementia, diabetes, cardiovascular disease, COPD, and limited mobility in need of nursing facility care. For your elderly and disabled there are significant annual costs per person to support the expensive 24/7 facility-based and group home based care and support. I will come back to the needs of these populations later in my testimony.

Medicaid expansion is an optional, category of eligibility to a new group of people. Adults, between 19 and 64, earning incomes up to 138% above the poverty line ($16,242 for individuals and $33,465 for a family of four). These adults don't have disabilities and many of them are without children.

Today 31 states and the District of Columbia have expanded their state Medicaid programs. The proponents of expansion have been fairly consistent in their messaging: Medicaid expansion is free; states will realize a windfall of federal funding, the federal funding will provide an economic boost, hospitals need Medicaid expansion to survive financially, jobs will be created, and this is the answer to the uninsured challenges.

When considering expansion, each one of these states looked at the problem, studied projections, and made a decision that this was a commitment and expenditure that their state could afford. Unfortunately, their projections were wildly understated. In fact the per person spending exceeded the Obama Administration's projections by 76%. States have experienced budget overruns far exceeding their original cost estimates. Similarly, states have experienced enrollment that in some cases is more than double their estimates. The total number enrolled under Medicaid expansion is 36% higher than the

Centers for Medicare & Medicaid Services estimated, 60% higher than the Urban institute estimated, and 55% higher than Kaiser estimates. Many individuals drop their employer-sponsored coverage and the accompanying cost sharing in order to take advantage of the "free" Medicaid benefit.

- Alaska's costs were 85% higher than projections: Projection: $320 million; Actual: $593 million over 2 years.

- California estimated enrollment of 910,000; The state has experienced explosive enrollment totaling 3.8 million; Their cost projections over 3 years were $11.6 billion and their actual costs were $43.7 billion; California's Medicaid spending overall has tripled, 30% of the state's population is now enrolled in Medicaid; Over the last 10 years, more than 62% of all new state spending has gone to Medicaid crowding out other state priorities.

- Illinois estimated that 342,000 would enroll but have enrolled over 655,000; The state estimated the program would cost $4.6 billion but has in fact cost over $9.2 billion over 3 years.

- Ohio: The Kasich administration estimated 447,000 would enroll but 725,000 have enrolled onto the state's Medicaid program; The program was projected to cost $7.4 billion and actual costs have been at $14.5 billion over 3 years. The Legislature recently voted to adopt a Medicaid expansion freeze and to require the Administration to submit a waiver allowing the state to freeze the program. The legislation was vetoed by the Governor. The Legislature is still considering an override.

And the list goes on.

These are the budget problems that states have experienced with a higher federal matching rate. By 2020, states will be responsible for 10% of the

funding. Of course there is ongoing debate about whether the federal government can actually maintain that financial commitment given other financial pressures at the federal level.

While there are many troubling aspects of Medicaid expansion, the following are some of the significant concerns:

- **Explosive growth in tax-payer funded Medicaid will crowd out other state priorities such as education, roads/bridges, public safety and add to your tax burden. It is not free. Medicaid is often referred to as the PacMan of state government budgets — aggressively consuming limited resources at the expense of other state priorities; Prior to the ACA and Medicaid expansion, state Medicaid programs had grown and were consuming one out of every 4 state dollars. Today, Medicaid expansion states are seeing one out of every 3 dollars going to Medicaid.**

- **Within Medicaid, the insatiable appetite for the "free" federal funding, distorts priorities within the Medicaid program and crowds out state funding commitments to our most vulnerable populations: our elderly and disabled. The ACA has created a golden circle around able-bodied adults; If your state budget tanks you won't cut the services where you are receiving a 90 – 95% federal match. You will have to cut the services where you are receiving a 60-50% federal match in order to make-up a state shortfall — those are the services for the elderly and disabled.**

- **State Medicaid programs largely fail to properly reimburse providers for the appropriate costs of care and lack a focus on and incentives for quality outcomes. The costs to cover enrollment growth further undermine any efforts to improve quality and increase reimbursement rates.**

- **We already have a significant crisis in our country with hundreds of thousands of jobs available and employers unable to find employees who will show up on time, drug free, and stay to the end of the day. Will "free" Medicaid further discourage able-bodied adults from pursuing employment and advances in employment in order to protect their benefit?**

I would like to share a little of my experience in Maine. When I became Commissioner of Maine's Department of Health & Human Services in February 2011, appointed by Governor LePage, the agency had been reeling from one financial crisis to another for more than a decade. The crisis-riddled finances were entirely focused on bailing out the boat. Here's why: Maine expanded Medicaid long before the ACA. Exceeding all cost and enrollment projections, the Medicaid program doubled in size for both enrollment and spending. From a price tag of $1.2 billion in 2000 to $2.4 billion in 2010 and from 180,000 people to 354,000 in 2011 – 30% of Maine's population enrolled.

Over that time, Maine couldn't pay its bills to hospitals accumulating a debt of over $750 million, nursing facilities closed, physician practices closed their doors to Medicaid patients, and worst of all an 85 year old in need of home-care services or a 40 year old with Down Syndrome, or a newly graduated 19 year old with autism, were put on waitlists for services in their home or community. In 2011, I had over 3000 elderly and disabled on waitlists while we were enrolling 25 year old able-bodied adults to Medicaid. In Maine the average annual cost for an individual with intellectual and developmental disabilities to receive 24/7 residential supports is $100,000. The mandatory entitlement spending on non disabled, non elderly adults in Medicaid expansion directly competes with the optional funding to support someone with Down Syndrome

Medicaid programs, because they are largely dictated to by antiquated federal regulations, have not kept pace with more convenient access to

services in people's homes. The federal regulatory structure of Medicaid is more focused on facility-based care like hospitals and nursing facilities and has restricted state flexibility in the provision of home-based services.

Imagine if your elderly mother or father could stay in their homes with just a little additional help with their day to day care. While states can provide these services, it is often done only after a cumbersome waiver process is approved and is typically managed under a budget cap. In this case, Maine had elderly individuals waiting for home-based care while adding thousands of able-bodied adults to the program. Or your elderly parent may require 20 hours per week of supports in her home to help her with activities such as bathing and dressing, but the home care agency can only provide staff to support 10 hours per week. Because Medicaid reimbursement rates fail to come close to covering the cost of care, that directly affects the home care agency's ability to pay competitive wages. The low wages often results in worker shortages which means the 85 year old going without critical supports in her home.

Medicaid programs generally have had a poor track record of appropriately reimbursing for the true cost of care and services. Medicaid programs have asserted for far too long that providers should be grateful for whatever they receive in reimbursement since its better than nothing. That is no way to run a safety net healthcare program for our most vulnerable citizens.

To end the years of financial crisis and the hemorrhaging of red ink, we rolled back Medicaid eligibility in Maine and reduced our overall enrollment by 25%. As a result of those decisions, we were able to finally get our financial house in order. By saying no to a repeat of history in Maine and rejecting Medicaid expansion, we have been able to increase funding for nursing facilities by over 40%, increase reimbursement rates for home care by over 60% and increase funding for individuals with intellectual and developmental disabilities by $100 million since 2011. We eliminated the waiting lists for our elderly,

eliminated one of the wait lists for community services for individuals with significant disabilities, and have been reducing the waitlist for disabled individuals in need of 24/7 group home supports. However, with the number of children being diagnosed with autism each year and as a greater number of children with disabilities graduate from high school, the Medicaid program is still not adequately funding current or projected demand for services.

Most alarming, Medicaid programs are rarely focused on quality of healthcare services. Most Medicaid programs are consumed with a transactional focus. Claims in and payments out the door. And if you have expanded Medicaid – the volume of work has only intensified that transactional focus. So for the billions of dollars spent annually on Medicaid – we can't even answer the question of whether there are improved health outcomes and whether the system is being used efficiently. We know that Medicaid enrollees use emergency room services at far higher rates than other individuals. In Maine, with our finances stable and our priorities firmly established, we have been able to focus on several key areas:

- Management of super-utilizers of emergency room services;
- Increased reimbursement for primary care physicians and state-wide financial support for evidence-based model of primary care focused on chronic disease management
- Establishment of behavioral and physical health integration through an incentivized payment model
- Implementation of a Medicaid Accountable Communities Model – similarly to Medicare's Accountable Care Organization
- Improved data analytics and predictive analytics to more effectively manage use of the system and to incentivize improved healthcare outcomes; All participating primary care providers receive dashboard reports for their patient panels regarding their ER utilization rates, adherence to

best practices such as monitoring of diabetic patients – as compared to their peer physician practices.

At the state level, there is a commitment to balanced budgets. We do not live in a world of unlimited resources. State safety net programs must protect and fulfill their core mission. As you well know, there is only so much money in the state budget. When state budgets are in a financial free fall, the situation becomes all about bailing out the boat and not charting a course. To address the crisis, critical priorities and populations are neglected and often taxes are increased on hard working individuals and on vital businesses. For all of these reasons, we would strongly discourage Utah from pursuing Medicaid expansion.

Thank you, again, for allowing me to speak today. I am happy to answer any questions.